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ABSTRACT

Urban Community Mental Health Centers (CMHC's) are faced with large case loads and long waiting lists. Clients failing the initial appointment represent a significant loss of staff time and resources to CMHC's. Despite the high rate of failed initial appointments reported, no studies have looked at means of reducing the failure rate. In the current study 88 subjects were assigned to one of four intervention groups. Group A received a letter three days prior to initial appointment; group B received a telephone call three days prior to initial appointment; group C received a telephone call one day prior to initial appointment; group D was a control. The content of the telephone call and letter were identical. Subjects were reminded of date and time of appointment and name of worker. The results showed a significant reduction in the rate of failed initial appointments. In Group C, 91% of subjects kept the initial appointments; in both Groups A and B, 68% kept their initial appointments. Only 45% of the control group kept their appointments. The effectiveness of these intervention techniques in reducing the failure rate, and thereby enhancing the resources of CMHC's , was discussed. Possible explanations for differences in the effectiveness of the three intervention techniques, as well as age, sex and SES variables, were explored. (Author)

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REDUCING FAILED INITIAL APPOINTMENTS IN A COMMUNITY MENTAL HEALTH CENTER

Neil J. Hochstadt and John Trybula, Jr.

Community Mental Health Centers in metropolitan areas are often faced with large client case loads and long waiting lists (Raynes and Warren, 1971 b). As the demand for therapeutic services increases most outpatient centers have difficulty providing adequate services. Raynes and Warren (1971 b) indicate that providing crisis intervention and short term therapy is a role that many outpatient centers are being forced into; often to the neglect of other services. As a result, clients may receive inadequate services and a large number of clients may never receive services at all.

CLIENTS WHO FAIL APPOINTMENTS

A major difficulty of many community mental health centers, and the center under study, is that of clients dropping out of therapy prematurely or clients failing the initial appointment. Both represent a great expenditure of the center's resources.

There have been a substantial number of studies concerned with the reasons and types of clients who drop out of therapy prematurely. Major reasons appear to be dissatisfaction with the services, conflicts with the therapist, and/or the amelioration of the presenting problems. (Kline and King, 1973; Kagan, 1957; Rosenthal and Frank, 1958; Shapiro, 1974).

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There have been a substantial number of studies concerned with clients who drop out of therapy prematurely once engaged. However, there have been few studies concerned with clients who contact the center and fail to become engaged in treatment by virtue of failing their initial appointment.

Research indicates that a fairly large percentage of clients who make an appointment for an initial interview fail to keep this appointment (for the duration of this paper the term initial appointment will refer to the client's first face-to-face session with a staff member following a request for an appointment). Gould, Paulson, and Daniels (1970) found that over a two year period a consistent 20 to 30% of applicants contacting psychiatric clinics for help failed or did not cancel their initial appointment. Other studies have indicated similar problems. Krause (1966) found that 44% failed or cancelled their initial appointments and Raynes and Warren (1971 b) report a 42.4% failure rate.

Findings of several studies indicate that clients of low socio-economic status tend to fail appointments more often (Pfouts, Wallach and Jenkins, 1963; Raynes and Warren, 1971 b; Robinson, Redlich and Myers, 1954). Raynes and Warren (1971b) found that clients least likely to attend the initial appointment are black, male, single, under 40 years of age, complain of symptoms due to the recent death of a relative or friend, and have to wait a longer time on a waiting list.

Gould, Paulsen and Daniels (1970) found no significant difference between

clients who kept or failed their first appointment as a function of the degree of reported crisis at the time of the initial call to the mental health center. Further, no significant difference between clients who attended or failed their initial appointment was found as a function of such variables as occupation, education, or income categories. The study found that clients with the most clearly defined reasons for seeking help tend to show up more often while those with the vaguest reasons tend to fail more often. Likewise, Noonan (1973) found no significant difference on variables such as age, education, marital status, and sex as related to keeping the initial appointment.

In a follow-up study Noonan (1973) explored reasons given by clients for failing the initial appointment. The largest group (39%) consisted of clients who were unable to explain why they failed. 35% indicated that between the first contact and the initial appointment their problems had improved sufficiently to make treatment unnecessary. 23% indicated a high level of anxiety regarding the impending appointment and 3% denied having contacted the center. Ginott (1961) obtained similar reasons from parents who failed to bring their children for the initial appointment at a child guidance clinic. Several studies (Heyder, 1965; Karner, 1964; Raynes and Warren, 1971 a; 1971 b; and Rosenthal and Frank, 1968) indicate that clients' motivation for therapy decreases as a function of increasing time on a waiting list. In addition, they found attendance rates increased when waiting lists were abolished. However, Gould, et al (1970) found no significant differences between clients who fail or attend on the basis of time between the initial call and the

appointment given.

In summary, research indicates that a large number of clients fail their initial appointment but the findings of studies exploring the reasons for the failed appointments are inconsistent.

INTERVENTIONS

The initial appointment, often referred to as the initial interview, intake interview, diagnostic interview or exploratory interview, can be lengthy and taxing on a center's resources. Decreasing the failure rate of initial appointments would benefit an outpatient center by reducing the waiting list, making more treatment time available, and generally making more of the center's resources available to the community. The present study was designed to asses the effectiveness of 3 types of interventions at reducing the initial appointment failure rate. The study was carried out at the Roseland Community Mental Health Center, one of 19 municipally sponsored community mental health centers, of the city of Chicago. The center had no fees and operated with a no decline policy. The center served a predominently black inner city, residential community that is made up of both middle income and low income populations. However, the incidence of unemployment, crime, and individuals on public assistance were high among the residents of the center's catchment area.

Like most urban community mental health centers this center had more clients than its staff was able to adequately serve. A major difficulty was that of clients failing their initial appointment. A 27 month collection of

baseline data indicated a 36% failure rate for non-aftercare clients who phoned for an initial appointment. These findings are consistent with previous studies.

Since there was no previous research in the area of cue utilization as a means of reducing the failure rate this was thought to be a good starting point. Elaborate and imparsimonious interventions which would themselves consume more time than lost through failed appointments were rejected. In addition, the relative effectiveness of two cuing procedures were looked at. Two interventions, which could be implemented expeditiously, at a minimum of cost, and by any staff member (including clerical) were used. These interventions were: 1) a letter sent to the client and, 2) a telephone call. Each was designed to remind (cue) the client of the scheduled appointment.

Several hypotheses were formulated. First, clients receiving a cue - be it a phone call or a letter - would have a lower failure rate than the control group. Second, the closer, temporally, the cue is to the appointment date the lower the failure rate. For example, a telephone call the day before the appointment date should prove more effective than a phone call three days prior to the appointment. Lastly, it was hypothesized that the telephone call would more effectively reduce the failure rate than the letter. This follows from Festinger's (1957) notion of "forced compliance" or "attitude discrepant behavior" and from Kohn, Brehm and Latane (1957) who found that individuals who publicly (overtly) commit themselves to a position discrepant from private beliefs tend to change their behavior to make it

more consistent with their public committments.

PROCEDURES

Subjects: Ss consisted of children, adolescents and adults who had no prior psychiatric hospitalizations. With the exception of 6 Ss referred by a physician all of the adult Ss were self-referred. All the children/adolescents were referred by a parent. Ss consisted of 15 adult males, 41 adult females, 18 children/adolescent males and 14 children/adolescent females. Ss 18 years of age or older were considered adults, those under 18 were considered children/adolescents. All Ss but 4 were black. Three Ss were Caucasian adults and 1 was a Spanish-American adult.

Intervention Procedure: The referrals to the center were made by telephone. The initial appointment was scheduled by a worker who assigned the client to the next available intake appointment. During the phone call the telephone worker recorded the following information concerning the client on a single intake card: name, address, telephone number (both home and work number), sex, race, age, source of referral, date of referral, date of initial appointment, intake worker assigned, and a brief description of the presenting problem.

Only new referrals to the center were included in the study. In order to avoid a time or waiting list bias only clients who had a minimum of a 4 day delay between their telephone call and the initial appointment were included. Ss were assigned to one of the four groups in sequence as they called the center. However, counter balancing, in order to minimize the waiting list

bias, was effected. All groups had an average wait of 10 days between initial call and initial appointment.

Ss in the three experimental groups were exposed to one of three interventions while the control group received no intervention. Group A received a letter reminding them of the date and time of their appointment and the name of the staff member. The letter was mailed to the client 4 days before their initial appointment. Ss were requested to bring the letter and the envelope with them to their initial appointment in order to ascertain when the letter was received. Of the 22 Ss in this group 10 returned the letter postmarked 3 days prior to their initial appointment. 5 Ss acknowledged receiving the letter but had forgotten to bring it. 7 Ss failed their appointments. Ss in group B received a telephone call 3 days before their appointment. Ss in group C received a telephone call 1 day before their appointment. Group D, the control group, received no intervention. The content of the telephone conversation was identical to the letter. Extraneous conversation was avoided so as not to influence the client. All telephone calls were made by the same experimenter. No Ss were dropped from the study as a result of expressing a desire to change or cancel their appointment during the course of the phone conversation.

RESULTS

The study was conducted during the summer months. In order to rule out seasonal variations as a salient factor in failing first appointments an analysis of the 27 months of base line data was conducted. The results

showed that there was no significant seasonal influence in the rate of failure of first appointments. During baseline 38% of the clients failed their initial appointment during the winter quarter (December, January and February), 37% failed during the spring quarter (March, April, and May), 37% during the summer quarter (June, July, and August), and 32% during the fall quarter (September, October, and November).

Table 1 presents the results of the interventions. A chi-square analysis indicates a significant difference between Ss who attended and those who failed the initial appointment as a function of the type of intervention x^2-10.48, df = 3, p. > 02). In group A (letter) and group B (3 day telephone call) 68% of the Ss kept their appointments. In group C (1 day telephone call) 91% of the Ss kept their appointment. In group D (the control) only 45% of the Ss kept their appointment.

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Insert TABLE 1 about here

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Because of the interest in all 6 possible comparisons the Alpha - level was recomputed for these comparisons. This is done by taking the .99 significance level to the 6th power and subtracting this value from (1- .99 to the 6th power = alpha). The alpha value arrived at was .06 for any of the comparisons. There was a significant difference between between C and Group D (x^2 = 10.48, df = 1, p>.06). There was no significant difference between any of the other possible comparisons between these groups.

TABLE 1
ATTENDERS AND FAILURES BY INTERVENTION

	A 3 Day letter		B 3 day telephone		C 1 day telephone		D control	
	No.	%	No.	%	No.	%	No.	%
Attenders	15	68	15	68	20	91	10	45
Failures	7	32	7	32	2	9	12	55

Of the 88 referrals, 56 (64%) were adults and 32 (36%) were children and adolescents. Of these, 33 were males and 55 were females. Table 2 presents data related to the sex and age of Ss in the four groups.

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TABLE 2

SEX AND AGE BY INTERVENTION

	A Letter	B 3 day telephone	C 1 day telephone	D control
	n=22	n=22	n=22	n=22
Males	9	11	7	6
Females	13	11	15	16
18 and over	13	13	15	15
Under 18	9	9	7	7

TABLE 3

FAILURE RATES

Overall	31%
Age over 18	36%
Age under 18	22%
Male	21%
Female	36%

IMPLICATIONS

The results of this study indicate that a relatively direct and parsimoneous intervention can significantly reduce the failure rate of initial appointments at a CMHC. A telephone call to clients the day before the initial appointment reduced the failure rate from 55% to 9%. Cuing, be it by letter or phone call, played a major role in reducing the failure rate. However, the temporal proximity of the cue to the appointment appeared to be more important than the type of cue. Consequently, a telephone call 1 day before the initial appointment was more effective at reducing the failure rate than either a letter or a telephone call 3 days prior to the appointment. Festinger's theory of "forced compliance" or "attitude discrepant" behavior did not account for these results.

The importance of these findings in making more effective use of a CMHC's resources is striking. The study demonstrated that 25% - 45% more time can be made available for initial interviews by calling clients the day before their appointments. With budget cutbacks and increased caseloads the ability to increase available staff time is most important for CMHC's. Further, this intervention may serve as a preventative measure by increasing the probability of clients receiving help for their problems when their need for service is high. Clients who fail their appointments are likely to take their difficulties back to their families and to the community; thereby increasing the probability of the need for services at a later time.

The current study has implications beyond the striking reduction in the failure rate. The first relates to psychological research in general. The second, more specifically related to research conducted in CMHC's.

This study was designed to look at the applicability of a simple research design in a community setting. For the most part psychologists tend to employ very elegant and elaborate research designs. Certainly the complexities of human behavior and multiple interacting variables often require such designs in order to extract meaningful findings. However, it seems advisable to start with simple designs, when feasible, and proceed to the complex only should the simple design fail to answer the questions posed.

The study also demonstrated that outcome measures, with practical significance to a CMHC, can be found and studied. Obscure dependent variables may have heuristic value but neglect the CMHC's need for applied - and readily applicable - research.

This brings me to my next point. Typically, research is given a low priority - if one at all - in CMHC's. In the mental health system under study most of what is euphemistically called research is data tabulation i. e., number of patient contacts, number of service hours, number of home visits made, etc. This data is important because it is used to justify the allocation and/or expenditure of funds. Administrators generally see no pay-offs in allocating staff time to research. Indeed, the consequences of engaging in research are often aversive. Much needed direct service time may be lost. The mutual

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suspicion that often exists between a community, the advisory board and the center's professional staff regarding research or experimentation is exacerbated. Consequently, research in CMHC's must have high face validity. The administration, the community via the advisory board and local funding agencies must be shown how applied research has immediate and demonstrable consequences in improving the services delivered by the CMHC. It is encumbent upon psychologists interested in applied research in CMHC's to demonstrate the relevance and applicability of the research.

The current study also highlighted the need to assess, hopefully, a priori, the impact of the research upon the homeostasis of the CMHC. At the outset the current study was avidly supported by the staff. However, the authors did not account for the fact that most staff members had developed uses for the predictable time spent waiting for clients who failed appointments, e.g., writing reports, phone contacts, etc. As the study progressed, and patients filled this time with more regularity, staff members had less time, became more overworked and clearly did not have the same enthusiasm for the research.

Lastly, it would be interesting for the current study to be replicated in other CMHC's and in other settings. For example, these findings have relevance to medical and/or hospital outpatient clinics where failure rates are also high. Additionally, other interventions and variables should be looked at to assess their effectiveness at reducing failure rates.

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